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**Framing health inequalities: investigating local action on health
inequalities in England, Scotland and Wales**

Tim Blackman, Barbara Harrington, Eva Elliott, Alex Greene, David J. Hunter,
Linda Marks, Lorna McKee and Gareth Williams

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Introduction

Towards the end of the 1990s reducing health inequalities rose up the agenda of governments in several countries, including the UK, reflecting a growing awareness of the existence and preventability of these inequalities as well as the financial cost of treatment if they were not addressed (Leon, Walt and Gilson 2001; Mackenbach and Bakker 2002; Wanless 2004). As an example of Kingdon's (2003) 'policy windows', health inequalities illustrate how a confluence of key factors can see a problem, previously neglected, enter the policy arena. Kingdon conceptualises these factors as three streams: a *problem stream*, where the strength of evidence brings a problem in or out of focus for policy-makers; a *policy stream*, which represents the ability of stakeholders to argue for the plausibility and feasibility of actions to tackle the problem; and a *politics stream*, where bargaining between power bases sees problems get more or less attention and action.

Mackenbach et al. (2002) link the entry of health inequalities into the problem stream to the better availability of national population and mortality statistics, but evidence of the problem needed to coincide with effective policy tools and a conducive balance of political forces for policy change to occur (Cropper et al. 2007; Kingdon 2003; Zahariadis 2008). In the UK the election in 1997 of a Labour government after eighteen years of Conservative rule saw a shift in the politics stream towards taking action on health inequalities but the new government also fundamentally changed the policy landscape by devolving power, including over health policy, to national governments in Scotland and Wales in 1999. These new governments, as in England, produced bold statements and strategies addressing health inequalities (Department of

Health 2000; National Assembly for Wales 2000; NHS Scotland 2000). As devolution developed, however, it became increasingly apparent that approaches differed, especially regarding the use of targets as a means of driving local performance from the centre (NHS Scotland 2005; NHS Wales 2005; Secretary of State for Health 2005; Smith et al. 2009).

In England, a fundamental premise of Labour's public services reform agenda was that centrally-determined targets were essential to achieve a focus at local level on the government's priorities (Barber 2007; Blair 2010). In Scotland and Wales the Labour Party was also in government from 1999, but in Scotland as part of a coalition with the Liberal Democrats (until replaced by a Scottish National Party minority administration in 2007) and in Wales as a majority government until entering a coalition with Plaid Cymru in 2007. There was little enthusiasm in these governments for England's 'command and control' regime: in Scotland because there was more of a culture of trusting professionals to work with policy agendas that they themselves tended to be more involved in shaping, and in Wales because of a culture of localism and less prescription from the centre (Greer 2005). These differences created an opportunity in the UK to compare how the national circumstances of a problem affect how it is framed, enabling us to investigate the normative character of policy problems and how this is further constituted by the narrative constructions of those given responsibility for local implementation (Fischer 2003; Schön and Rein 1994).

Researching this issue invites a sociological perspective, not just as part of the interpretive turn in policy studies that has sought to understand goals and purposes without any particular claims about causes, but also because interpretive analysis can

offer policy-relevant insights (Gabe and Calnan 2009; Popay and Williams 2009; Wilkinson 1996; 2005). A significant aspect of this work is how the problem is constructed and prioritised. Exworthy, Blane and Marmot (2003) argue that when health inequalities came onto policy agendas in the late 1990s the policy stream did not couple effectively with the problem and political streams because there was neither the knowledge nor the commitment needed to overcome the forces driving health inequality. Exworthy, Berney and Powell (2002) also argue that while coupling occurred to some extent at a national level in England – enough for the issue to be on the policy agenda – this was weak and patchy at a local level. They suggest that the reason for this was that the central performance management of health inequalities was less than for other imperatives in health policy, especially reducing waiting times for treatment, which in reality had higher priority and more visibility in media discussions about failings of the health care system.

These authors were writing at an early stage in the implementation of New Labour health inequalities policy and only considered England. As we see below, policy developed over time and the nature of performance management was quite different in Scotland and Wales, offering an opportunity to explore what effects this had on narrative styles and constructions, and what this reveals about the normative character of health inequality as a policy problem.

Research design: investigating local health inequalities policies

Our study was funded by the UK Economic and Social Research Council's Public Services Programme and brought together a team from Durham University, the

University of Aberdeen and Cardiff University. The project was submitted for and received NHS ethical approval. We interviewed senior professionals in the NHS, local government and local partnerships in each of the three countries of Great Britain, exploring how national policy was reflected in local narratives as well as how these narratives constructed the problem and response to it locally. Interviewing was conducted in a regional urban centre and ex-mining/industrial hinterland areas in each country, selected to achieve some comparability of geographical context and health status. In each locality we mapped the organisations responsible for local policy delivery and the key post-holders whose responsibilities included health improvement. In England, these organisations were the NHS primary care trusts (PCTs), the local authorities and local strategic partnerships (LSPs). In Scotland they were the NHS health boards (HBs), the community health partnerships, the local authorities and the community planning partnerships. In Wales they were the NHS local health boards (LHBs), the local authorities and the health, social care and well-being partnerships.

We undertook semi-structured face-to-face interviews in two phases during May-August 2006 (n=130) and January-June 2008 (n=67). In total, eleven chief executive interviews, seven director of public health interviews, 25 performance or finance manager interviews, and 40 interviews with other senior post holders such as partnership officers and topic leads were conducted in England; in Scotland we carried out twelve chief executive interviews, four director of public health interviews, 23 performance or finance manager interviews, and 26 interviews with other senior post holders; and in Wales we undertook nine chief executive interviews, seven director of public health interviews, fourteen performance or

finance manager interviews, and 19 interviews with other senior post holders. The lower number of interviews in phase 2 mostly reflects a smaller number of organisations due to restructurings over the intervening period. Few problems were encountered accessing these senior staff; we had three refusals in the first phase and six in the second phase.

The interview schedules were semi-structured and the topics covered how respondents' organisations defined health inequalities, understood their causes and approached tackling them; how performance was assessed; whether and how policy or practice had changed between the two interview phases; how reducing health inequalities compared with other priorities; whether specific targets were used and their nature; views on partnership working and its advantages and disadvantages, and examples of partnerships working well and not so well; the impact of joint appointments across the NHS and local authority; the main drivers for the organisation's work on health inequalities; prospects for the future; and the perceived seriousness of government commitment to narrowing health inequalities compared to other priorities. Interviews lasted about 90 minutes and were recorded, transcribed, checked and imported into NVivo for analysis. This used systematic indexing of themes, starting with the themes in the interview schedules and developing the framework as the analysis proceeded, and undertaken by the research assistant (BH) with a sample of transcripts also read by the lead investigator (TB) and members of the project team. The research assistant prepared draft thematic analyses, supported by direct quotations. This was an inductive process involving compiling profiles of organisations built up from the data from respondents, localities built up from the organisational profiles, and countries built up from the locality profiles. These

revealed patterns of similarity and difference by role, type of organisation, locality and country that were discussed initially by the national teams and then by full meetings or teleconferences of the whole team and in meetings of the project's advisory group. These discussions took the work beyond thematic indexing to an interpretive analysis that drew on the wider knowledge and expertise of members. In addition, results from the project were presented to a mixed policy and academic audience at a conference in Durham in March 2009, to which all participating organisations were invited and which further informed the analysis.

In this paper, we discuss the major themes which emerged from the interpretive analysis: *politics, audit, evidence* and *treatment*. We consider these as 'framings', which enable exploration not only of 'what' a policy means but also 'how' it means (Yanow 1996). Our actors were at the 'meso-level' of policy implementation where local service delivery is managed and shaped (Nutley, Walter and Davies 2007). They are interpretive communities or 'parties to the debate' as Fischer (2003, p. 143) describes, drawing on Schön and Rein's (1994) work on frame-reflexive discourse to ask:

'(H)ow is the policy issue being conceptualized or "framed" by the parties to the debate? How is the issue selected, organized and interpreted to make sense of a complex reality? The framing of an issue supplies guideposts for analysing and knowing, arguing and acting. Through the process, ill-defined, often amorphous situations can be understood and dealt with ... (F)rames highlight some issues at the same time that they exclude others.'

Particularly important is to understand defining claims, such as about priorities or how success is identified, because these serve to justify specific courses of action. The first framing we identify is *politics*; the process of whether and how an issue becomes defined politically as a problem needing state action. The second is *audit*, or the scrutiny processes characteristic of new public management that aim to exercise arm's length control over local implementation, based on the use of targets, performance indicators and sanctions (Clarke 2006; Travers 2007). The third is *evidence*, which is an important type of framing in health policy and practice, representing a particular type of empirical knowledge produced by a research process, and mediated by interpretation and prevailing paradigms (Nutley, Walter and Davies 2007). The fourth is *treatment* or the influence of the medical model and pharmaceutical interests in framing health problems as questions of individual treatment using health technologies, rather than having social causes and solutions (Williams 2003). These framings are summarised in table 1 and discussed in turn in the following sections.

Table 1 near here

Framing health inequalities politically

There were political changes in all three countries between the phase 1 and phase 2 interviews. In England, Labour remained in power but the prime minister changed from Tony Blair to Gordon Brown. Health inequality was generally seen by our respondents to be a high priority under both leaders but only to have become embedded in mainstream practice and performance monitoring by phase 2. Rather than a linear process of policy consolidation, the lack of mainstreaming in 2006 was

not because of it being an early stage of policy development but because the NHS was preoccupied with a budget crisis while being under intense government pressure to meet hospital waiting time targets. By 2008, finances and waiting times were under control, allowing health inequalities to rise up the policy stream and receive more attention. However, the conditional commitment to the problem, as a priority that could be eclipsed by other imperatives, was revealed again by respondents talking about the reorganisations that had taken place since 2006. These were meant to improve the efficiency of how services were commissioned and delivered, but were experienced as impeding the partnership working needed to tackle health inequalities by causing churn in personnel and disrupting relationships. The chair of an LSP commented:

‘Structural change and reorganisation has consistently got in the way of actually focusing on issues that we need to deal with in the city. My big frustration is that I’ve sat in meeting after meeting after meeting where people have been talking about who’s round the table, who is involved, who’s not involved and I keep saying, “I don’t care. I want us to get on and do things”. Every six months we have another discussion about who sits round the table.’

The instability caused by reorganisations under England’s command and control regime contrasted with Scotland where the NHS was described as relatively stable. The Scottish National Party narrowly assumed power in 2007 and this was said by some to bring a strengthened resolve to prioritise public health and tackle health inequalities. Local partnerships were widely regarded as working well and relationships between individuals across organisations were often long-standing, with

informal contacts described as common. There was also a strong theme of a public service value and a shared commitment to working together across local government and the NHS.

In contrast to England and Scotland, respondents in Wales did not see any strengthening of the health inequality agenda at the national level over the period. Following the new coalition government of Labour and Plaid Cymru coming to power in June 2007, some felt that the issue had become even more eclipsed than under a Labour majority administration in 2006, when most of our respondents saw the priority of the Welsh government to be waiting times and financial balance in the NHS. There were comments that the new health minister was preoccupied with acute services, centralising control and populist measures that focused on care services and treatment. This example is from a director of public health:

‘It’s pretty clear to me that over time the priorities have shifted evermore towards waiting times and financial balance. If anything, I’d have to say that’s probably happening more now as the financial uplifts for the NHS begin to die away and, especially, if we end up in economic crisis. So, the warm words are still there but it’s difficult to link that through to a coherent attempt at solving health inequality.’

There was a view that, despite broad encouragement of a wider wellbeing and equality agenda through locally developed Health, Social Care and Wellbeing Strategies the Welsh government was not focusing on health inequalities.

In general, it was felt that the priority given by the government to waiting times, against which there were targets and local sanctions, was constraining the availability of NHS funding to develop new services that could target inequalities and skewed local priorities towards those that were considered to have disciplinary consequences for senior managers.

We can consider these local narratives against the policy background in each country. Devolution created conditions for different party politics and distinct policy debates and actions (Greer 2005; 2009). In England, at the time of our interviews over the period 2006 to 2008, there was a commitment to ‘narrowing the gap’ by reducing ‘differences in health between those at the top and bottom ends of the social scale’, with performance assessment against targets and an emphasis on encouraging and enabling people to ‘make healthier choices’ (Secretary of State for Health 2005: 10 - 11). In Scotland, the focus was on increasing the rate of health improvement in the most deprived areas, and emphasising wider determinants rather than individual behaviour change: ‘addressing aspects of poverty such as improving people’s employability, increasing young people’s confidence and skills and regenerating the most disadvantaged neighbourhoods’, also on the basis of setting targets to increase the rate of health improvement (NHS Scotland 2005: 22). In Wales, in a gradual shift from an early social determinants approach, references to tackling health inequality in policy documents were more tentative because, for reasons discussed below, the politics stream had become preoccupied with improving access to health care rather than prioritising public health. Moreover, discussions about health improvement were increasingly framed in terms of behaviour change, marked by the launch of Health Challenge Wales in 2004. So although there was an aim was to ‘improve health and

reduce, and where possible eliminate, inequalities in health' there was an overriding emphasis in policy documents on modernising services and improving access to care, while also addressing behaviour related to smoking, diet and alcohol (NHS Wales 2005: 4).

To understand the politics of how health inequalities were constructed for policy intervention we need to consider aspects of each policy regime. In England, Labour adopted area-based initiatives as an approach to 'joining up' action across a number of policy fields (Clark 2002; Smith 1999). In the case of health policy this represented an explicit commitment to narrowing inequality; from 2001, PCTs that included within their geographical boundaries local authority areas scoring in the bottom 20 per cent nationally on an index of deprivation and poor health - known as 'Spearhead areas' - were required to demonstrate how they were narrowing their gaps in life expectancy. The national target was a 10 per cent narrowing by 2010 between the Spearhead areas and the national average (which, according to the National Audit Office (2010), will not be achieved). Scotland also used an area-based approach, but to identify small areas where the government wanted to see faster improvement in health outcomes rather than to measure the gap between these areas and the national average. One of the challenges of the English approach was that national average health outcomes are likely to increase faster than those for the most deprived areas, making the English strategy a demanding game of catch-up. The Scottish approach avoided this, but appears to have been framed not as an easier option but because there was no acceptable reference point. A senior civil servant explained to us that the Scottish government did not want to have an objective of narrowing the gap between the most deprived areas and the Scottish average because the averages for key measures such

as life expectancy were among the lowest in Europe, so not something to aspire towards. The alternative of measuring the gap with the UK or England was not politically acceptable to a Scottish government. A monitoring report published in 2006 noted that progress was on target for all the health inequality targets, which were due to be met in 2008 but were not further reported on (Scottish Government 2008).

Wales presents a scenario where we see the overlapping influences of different framings. Comparison was also important for the Welsh government: not, as was the case in Scotland, rejecting comparison with England, but instead finding itself ineluctably and unfavourably compared with England, and to some extent Scotland, in the media. These comparisons were about waiting times for treatment, the rise in which compared with England's reductions forced the government to move away from the public health emphasis of its health minister Jane Hutt and prioritise improving access generally to health care, with the controversy accompanying the waiting time figures leading to Hutt resigning. However this shift at national level was paralleled by a persistent belief in the strength and value of local governance and action, particularly regarding areas requiring cross-sectoral solutions. From 2003, Health, Social Care and Wellbeing Strategies were the joint legal responsibility of local health boards and their coterminous local authorities for the planning of health services and relevant local authority activities. The first guidance on these strategies stressed *local* leadership, responsibility, coordination and analysis (Welsh Assembly Government 2003). Whilst there were national targets for health care organisations to reduce waiting times, efforts to address health inequalities were felt to be a matter for local performance management and self assessment. This is also reflected in the approach in Wales to local authority performance which focuses on local autonomy

and self assessment (Downe et al., 2010). At the time of our study, there were no national targets for tackling health inequalities that were required to be adopted by local NHS organisations in Wales or local authorities.

Audit framings of health inequality

In the English localities, respondents in the PCTs generally welcomed how national targets had acted to prioritise work on health inequalities, even though these targets were often said not to be real ‘bottom line’ priorities equivalent to balancing budgets, waiting times and patient safety. Some still saw health inequality as a ‘Cinderella’ area where demonstrating value for money was harder than for competing claims on spending from acute services, although certainly more positive comments were made in 2008 than in 2006 about the amount of spending on tackling health inequality. PCT respondents said they were prioritising the issue in how they commissioned services. A PCT director of performance development said:

‘We’re putting our money where our mouth is more than we were. Our annual operational plan is a very direct alignment of the rhetoric with the actual practicalities of deploying resources and the outcomes of course do reflect some of the longer term NHS plan targets ... There's a whole range of things clustered now under there so the targets in that sense are far more aligned to the longer term preventative regime than they've ever been.’

There was also some re-thinking of how health care services needed to change. We were told that the NHS could work against narrowing health inequalities because of

the ‘inverse care law’: those with the greatest ill health have least access to the services they need (Tudor Hart 1971). Health inequalities, therefore, needed a dedicated proactive approach, as explained by this director of public health:

‘We realised a couple of years ago that actually we were potentially increasing health inequality. So we’re now focusing on our harder to reach groups ... They’ve got more baggage and problems and difficulties, so in a way the more we target and try and reduce inequity the harder the job gets ... But that’s good, it’s just hard.’

In Scotland there was less talk about targets than in England, although waiting times figured prominently when targets were discussed. The targets for health improvement were generally regarded as useful, but there was little of the narrative in England of actions driven by targets, and a view that performance managing health inequalities too closely could inhibit the trial and error approach needed to learn how to tackle complex issues. An HB director of public health commented:

‘There’s more of a national understanding now that we need to start adopting this continuous improvement philosophy rather than just simply stamping you’ve not done this and you’ve not done that, you’ve not hit this trajectory ...

Even if you can’t say this will lead to a two per cent reduction in health inequalities, even though you can’t prove that, you can legitimately say “yes but it will impact because we’ve used the best evidence that we have available to show that this is the correct continuous improvement route”’.

Scottish respondents were more likely than in England to talk of the complexity of health inequality, in which health care interventions had limited relevance and short term targets little applicability. This caused some frustration that the case for more spending was hard to make. There was a view among Scottish respondents that health inequalities were not really influencing how NHS budgets were deployed because of the difficulty of making a cause-effect connection. The speculative and long-term nature of any pay-back on spending was described by this health board performance manager as a problem when it came to shifting resources:

‘The difficulty is that the time span is going to be quite a number of years, maybe even half a generation, and you need the resources to invest in that end, but you’re not going to see any savings for maybe twenty years. So it’s not about, you know, we’ll stop treating people for heart attacks and instead we’ll stop them smoking.’

In Wales, there was little evidence of health inequalities being an operational or spending priority; health inequalities was said not to figure in any performance assessment frameworks and the health agenda was regarded as driven by waiting times. The performance management system for the NHS in Wales was described as making policy by default because meeting waiting time targets was rewarded financially and sanctions were imposed for poor performance, so other concerns were inevitably a lower priority. A health board director of finance observed:

‘I’m not saying that we’re told not to deliver on health inequalities but you’ve got to achieve the service targets and they’re the ones you’ll be criticised on

... the number one priorities such as waiting times for accident and emergency, cancer and cardiac ... If you fail to achieve the targets essentially they are imposed on you.'

There were few references in the Welsh interviews to gauging the scale of local health improvement that was needed and targeting interventions, but a lot to coping with demand on services. Some NHS respondents did regard health inequalities as a top priority but the variability in these views reflected the lack of a strong national steer. Local authority respondents talked of the issue as important and addressed by work on regeneration, skills and housing, including targeted social programmes, but there was little evidence of specific plans to address health inequalities driving resource decisions. This comment by a board partnership manager captured a general theme in many interviews:

'The health and well-being strategy is really all about tackling health inequalities. But a lot in there hasn't actually required putting resources into it ... you know, putting your money where your mouth is.'

We can see the different national audit cultures reflected in these narratives but not quite as might be expected. In England, the 'command and control' audit culture associated with New Labour public sector reforms has been dubbed a regime of 'targets and terror' (Bevan and Hood 2006: 421). This is because of the use of managerial sanctions for under-performance, which has much less prominence in Scotland and Wales where there has been more emphasis on co-operation and collaboration between levels of government. However, we see little 'terror' about the

health inequality targets in local narratives and they were often welcomed as signifying that health inequality was high in the problem stream because progress was audited, even if the reality of the political stream was that these targets did not represent high stakes for senior management.

Scotland adopted health inequality targets in 2004, not only later than England but in the context of Scotland's different performance regime. The targets were aimed at health improvements in the most deprived fifth of small area data zones, focusing on reductions of generally around 10 per cent between 2003 and 2008 in cancer and CHD mortality and smoking prevalence. Scotland's local health boards were required to report annually to the Scottish government on what they were doing to meet an agreed trajectory for each board to meet these targets. Face -to-face meetings involving government ministers and emphasising self assessment reflected a partnership approach between politicians and professionals.

Wales also adopted national health inequality targets in 2004. These, however, were not quantified and aimed at a more rapid but unspecified reduction in mortality from coronary heart disease and cancer among the most deprived groups compared to the national average. In addition, in 2006 a series of national child poverty targets were published that included several measurable health inequality targets. None of these were performance indicators for local NHS or partnership organisations against which they were required to account for their performance. This is not to say that there was no requirement to address health inequalities or no assessment of progress. The Healthcare Standards for Wales outlines in standard 29 the requirement of health care organisations to address health inequalities through Health, Social Care and

Wellbeing Strategies (Welsh Assembly Government 2005, p. 14). A balanced score card was introduced to support self assessment of performance against internally agreed plans and targets to meet the standards but, as interviewees emphasised, these were local targets with no reference to how they connected with national health inequality targets. Alongside little reporting of comparative data this reflected the localist paradigm in which devolution in Wales was implemented, within which local government had more influence and autonomy than its English and Scottish counterparts, including less intensive performance assessment from the centre (Blackman et al 2006, Downe 2010).

Evidence framings of health inequality

Respondents often said that decision-making was evidence-based, but published research was rarely referred to and evidence generally meant good practice gleaned from conferences or official guidance. Very few respondents pointed to evidence that their programmes to tackle health inequalities were having a measurable effect. Why local trends were going in the direction that they were could rarely be explained. Epidemiological evidence was said to be influential in the English localities in supporting investment in early detection and treatment but in Wales evidence from evaluations of government funded area-based health initiatives was said to be overshadowed by the powerful position of hospitals and their spending needs. In Scotland we found a trend in respondents' accounts between 2006 and 2008 towards increasingly focused and evidence-informed initiatives, mainly to support healthier lifestyles, and often with evaluation built into the design of the intervention. There was in all countries a surprising lack of scepticism about lifestyle interventions given

how limited the evidence is that these interventions can be effective among low income groups, and the time and effort they generally need compared to their mostly modest results (Jain 2006; Michie et al. 2008). Health indicators were commonly regarded as demonstrating how much needed to be done rather than a means of assessing whether the right things were being done.

In Wales, local authority respondents often said that existing services by their nature were narrowing health inequalities over time because local public services were mainly supporting poorer people. This head of performance management in one of the local authorities commented that if framed as a strategy to address health inequality his services would be meeting this objective:

‘So if you looked and if you set out all these different services, yes you could put it under an all-embracing health inequality programme ... I’m sure they all make a contribution but there’s no overarching policy.’

This view was felt by public health respondents in Wales to result in a non-committal, unfocussed and ultimately disengaged approach to what should have been a joint effort to address health inequalities. Area-based health interventions funded by the Welsh government such as the Sustainable Health Action Research Programme and the Inequalities in Health Fund had evaluation built into the programmes, but public health professionals locally struggled to find ways of using evidence in ways that would lever resources from either NHS or local authority funds. At the time of our study local public health directors were employed by the National Public Health Service and not the local health boards, where they served as non-executive board

members in a role they often saw as structurally weak in informing local strategic and commissioning priorities.

These accounts contrast strikingly with the extent to which evidence-based practice is often claimed to have become a paradigm for the British NHS. For health inequalities, both the problem and policy streams have been compromised by how difficult it is to establish generalisable knowledge that demonstrates ‘what works’, making it harder to move the issue up the political stream especially when short term progress over electoral cycles is so difficult to demonstrate. The aspiration among many public health practitioners and researchers is still that tackling health inequalities can be evidence-based, whether by using schematic ‘logic models’ that aim to predict and then evaluate multiple contributions to health outcomes, or by integrating a wide range of quantitative and qualitative evidence to assess the distribution of effects (Petticrew *et al.* 2009). However, as we see in the next section, the need for evidence that policy commitments are getting results can bias action towards what is likely to have short term effects. This was most evident in the English localities, where there was an imperative for performance indicators to show progress.

Treatment framings of health inequality

Rychetnik *et al.* (2002: 125) point to the way that an evidence hierarchy which privileges randomised controlled trials may attenuate options for improving health, biasing what is regarded as evidence-based practice to:

‘... interventions with a medical rather than a social focus, those that target individuals rather than communities or populations, and those that focus on the influence of the proximal rather than distal determinants of health’

The treatment model is often regarded as reflecting the dominance of hospital consultants and technological medicine, but it also reflects popular attitudes about health. We saw this demonstrated by the way that the Welsh government had to prioritise treatment in the face of media comparisons with English waiting times, eclipsing the earlier commitment to public health. However, we also found that in England the health inequality targets were focusing action on medical interventions. This was a clear trend in the interviews between 2006 and 2008, with the importance of finding people in the community at risk from deadly diseases and getting them into treatment heightened by the imminence of the 2010 targets. This up-scaling of interventions based on early detection and secondary prevention using drugs such as statins, antihypertensives and smoking cessation aids was policy driven, and strongly influenced by the national audit regime and associated guidance and tools (Bentley 2008). This increasing focus on treatment was not so apparent in Scotland, where projects to improve local economic and social conditions and promote healthier lifestyles featured more in respondents’ accounts. It is likely that the absence of strong pressure from targets was an important factor in this respect, but Scottish respondents were more likely than their English counterparts to bemoan a lack of influence on spending to tackle health inequalities. This appeared to be linked to the medical case that actors in England could make for spending on measures to reach people currently not presenting with conditions that could be managed with prescribed treatments, given the strong policy endorsement of this paradigm and its expected short term

effects on mortality. Making a budgetary case for preventative health improvement measures was much more difficult because of the longer and more speculative pay back.

In Wales, with an absence of national targets translated into local performance assessment, no strong national policy steer was perceived locally and health inequalities were not addressed systematically in local planning or budgeting. Between 2006 and 2008, policy in Wales was seen as either not having moved on or having shifted away from tackling health inequalities because of the government's preoccupation with hospitals. This was partly seen as political opportunism given the prominence of hospitals in the minds of the public and media, and partly as a reality given the burden of poor health left by the legacy of past heavy industry. In this context, Welsh policy was said to have an emphasis on *equity* that skewed attention to access issues. Health inequality – inequalities in outcomes rather than access to care - had little specific focus.

Conclusion

In policy analysis, framing reflects a balance of influences, political and managerial, on understandings of ends and means (Daviter 2007; Greer 2005). Thus, it is often argued that England's widespread use of performance indicators frames action to implement policy in ways that mean 'what's measured is what matters' (Bevan and Hood 2006: 517). It has also been argued that by constructing issues narrowly, performance indicators engender less effective practices and, combined with an oppressive emphasis on compliance and sanctions, encourage gaming (Seddon 2008;

Tilbury 2007). In England, the coalition government formed between the Conservative and Liberal Democrat parties following the May 2010 general election has been forthright in blaming Labour's 'top-down' targets for creating a mentality in the NHS and local government that put process before outcomes (Secretary of State for Health 2010).

Interviews in the English localities revealed a more complex picture. Shifting framings of targets was significant despite 'policy' not changing: political pressure focused the minds of local actors in ways that neither audit nor evidence could do on their own. In 2006, what mattered in England were ministerial exhortations and directives to meet the targets for waiting times and financial balance. By 2008 these issues were under control and the health inequality targets came more within the frame, although not immune from managerialist efforts to improve the efficiency and effectiveness of health care delivery. Boosting primary care came to be seen as the way to make short term progress with meeting the 2010 targets and this over-rode any evidence-based arguments about the need to direct more resources upstream to tackle health inequalities preventatively, especially as such evidence lacked information about cost-effectiveness (Wanless 2004).

Respondents in Scotland worked under a less strong target regime and often echoed some of the criticisms made of targets in the literature, especially their applicability to complex problems (Hunter and Marks 2005; McCormick and Fulop 2002; Seddon 2008). However, while both the Scottish and Welsh interviews often revealed an evaluative culture locally that recognised the complexity of health inequalities, this generally appeared not to be influencing the allocation of NHS resources, while local

government services were often assumed to be contributing to narrowing health inequalities rather than this being demonstrated.

The power of the political stream is clear from our analysis. In England it ran though how audit was perceived in practice and shaped the policy stream that in phase 1 was more attentive to waiting times and budgets than health inequality, and in phase 2 delivered the medicalisation of health inequalities as a way of meeting short term targets. In Wales the political stream moved away from tackling health inequality under pressure from a media-led framing of the country's health problems as a failure to match England's waiting times and deliver equity of access to health care. In Scotland, tackling health inequality was seen by respondents as the object of joined-up working to tackle the issue facilitated by a political stream that engendered stability and partnership working, but Scottish public health directors still bemoaned their inability to bend NHS spending. Only in England were there clear accounts of such bending because this was target driven. In none of our localities in any of the countries did we find a clear link in actors' accounts between what was being done and the evidence for doing it, beyond broad generalisations. There was also as yet little systematic learning from the interventions that were being pursued, a finding echoed in a UK Parliament committee investigation of health inequalities (House of Commons Health Committee 2009).

While evidence of the problem may be deployed in these narratives, scientific forms of knowledge such as epidemiology cannot be used as any kind of trump card because policy and political streams reflect other factors such as the availability of tools and levers to deliver change, media pressure, hospital power, stances towards working

with targets, working in partnership and working with evidence, and timescales driven by electoral cycles. In developing a sociological approach to health inequality as a field of investigation and action this kind of understanding is necessary to move us beyond rather naive linear ideas about the relationship between the ‘best evidence’ and strategies for what is to be done.

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Table 1. Alternative framings of health inequalities in selected localities of England, Scotland and Wales, 2006 -2008

	<i>Political framing</i>	<i>Audit framing</i>	<i>Evidence framing</i>	<i>Treatment framing</i>
England	High priority to narrowing the gap between areas initially eclipsed by pressure to reduce hospital waiting times and budget deficits, and impeded by reorganisations. Health inequalities increasingly constructed as a health care issue of earlier diagnosis and treatment.	Health inequalities framed as national and local targets, promoting local action and rising spending, with strengthening focus on role of NHS services in making short term gains. Failure to achieve targets not a high stakes issue.	Evidence-based framings increasingly dominated by treatment model of intervention and weak with regard to social determinants and lifestyle interventions which lack causal modelling.	Imperative for performance indicators to show progress against targets biases action to early detection and medication, where there are significant spending increases reported.
Scotland	Strengthening priority to improve health in the most disadvantaged areas, with shared commitment and stable relationships across local government and NHS partnerships and levels of government, and strong acknowledgement of social determinants.	Targets for health improvement are not strong framings, with emphasis on local innovation and evaluation of what works, and acceptance of long time spans for change to occur. Failure to achieve targets not a high stakes issue.	Evidence-based framings strengthen, mainly as an evaluative approach to lifestyle interventions, but expected long-term gains too intangible to affect spending significantly,	Treatment model subordinate to emphasis on living conditions and lifestyles, but not perceived as reflected in significant spending increases because of the difficulty of making a financial case.
Wales	Weakening priority after social determinants discourse is eclipsed by media-fuelled preoccupation with acute services and waiting times and politically damaging comparisons with England. Health inequalities increasingly constructed as issues of lifestyle as well as access to care.	Local delivery of standards with no connection to national targets or national performance assessment. Health inequalities not universally an operational or spending priority locally beyond access issues. Health agenda more driven by waiting time targets.	Evidence available from evaluations but overshadowed by hospitals and their spending needs. Health problems framed as a legacy of past heavy industry.	No systematic addressing of health inequalities locally. Preoccupation in deprived areas is with access to treatment.